Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS A licensure survey was conducted from June 24, 2009 through June 26, 2009. A random sample of two residents was selected from a resident population of four women with various disabilities. The findings of the survey were based on observations, interviews with direct support staff, residents, nurses and program coordinators in the home, as well as a review of resident records, administrative records, and incident reports.	R 000	Recvd 7/28/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven years, in all jurisdictions within which the prospective employee or contract worker had worked or resided within the seven years prior to the check, for two of seven employees. The findings include: Review of personnel records on June 25, 2009, beginning at 10:28 a.m., revealed that the GHMRP failed to ensure criminal background checks were on file that disclosed a seven year criminal history in all jurisdictions where the employee worked or resided, for staff S2 and S4.	R 125	The Human Resources Department will provide background checks for staff per regulation.	8/15/09

TITLE President (X6) DATE 7/27/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Eva P Jas

alth Regulation Administration

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

IE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTH CARE RESOURCES	2608 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 125	Continued From page 1 This is a repeat deficiency. ********** Previously, the Licensure Report, dated April 15, 2008, included the following: Review of the personnel records on 4/15/08 at 2:30 PM revealed that the GHMRP failed to provide evidence that ensured criminal background checks were on file for the Qualified Mental Retardation Professional.	R 125	See above response	

alth Regulation Administration

STEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	[redacted]

NE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 082	Continued From page 2 1. There was no cups or cup dispenser located in the bathroom located on the third level. 2. There was no cups or cup dispenser located Resident #3's in the bathroom.	I 082	The Lead Counselor will follow a daily Check list to ensure all supplies are stock In bathrooms and kitchen	8/27/09
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to maintain the interior and exterior of the GHMRP in a safe, clean, orderly, and attractive manner . The findings include: Interior: During the inspection of the interior of the GHMRP on June 26, 2009, at approximately 10:39 a.m. the following was obeserved: 1. The upholstery of the love seat located in the living room was torn, exposing the foam padding inside. 2. The sliding door to the closet located by the front door would not open from one side. In addition, there was no guidance track for the door; therefore, the door came forward instead of sliding to the side when the handle was pulled.	I 090	1. Furniture will be replaced. 2. The sliding doors will be repaired.	8/27/09

alth Regulation Administration

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	08/28/2009

IE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 3 3. The bathroom that was located at the far end of the upper hallway had dish washing powder stored in the cabinet below the sink. 4. Shelves in the kitchen cabinet that held spices, plastic bags, potatoes and onions were sticky and soiled. 5. The hood over the stove had a build-up of grease and was sticky to touch. 6. A mirror located in a closet located in the upstairs hallway was not mounted and could easily pose a risk of falling, breaking and causing harm to the residents. 7. Residents #1, #2 and #3 had their shoes being kept on the floor in their closets. 8. The emergency exit door located in Resident #2's bedroom was obstructed by tapes and CD's on the floor. 9. The shower stall in the bathroom located at the far end of the upper hallway had mold/mildew on the walls and on the floor. A shower chair located in the shower stall was dirty and stained. 10. The floor of the cabinet under the kitchen sink was rotted. The QMRP acknowledged that there had been a water leak for an extended period. 11. There was black and orange mold/mildew growing in and around the bathtub (including the tiles) in the bathroom located at the top of the stairs, next to Resident #1's room. 12. The closet doors located in the residents' rooms were off track which made it difficult to	I 090	3. The Lead counselor will daily check under sinks on each shift to ensure all supplies are properly stored in locked closet. 4. The Lead Counselor will follow daily check list to ensure all duties have been completed. 5. The Lead Counselor will ensure All assign duties are completed At the begin and end of each shift, according to housekeeping schedule 6. The Lead Counselor will ensure mirror Is removed. 7. The Lead Counselor will purchase shoe Racks for each individual's closet. 8. The Lead Counselor will ensure obstruction removed from exit door and stored.. 9. The Lead Counselor will ensure shower is cleaned Routinely and mold/mildew according to house keeping schedule. 10. The Lead Counselor will submit a repair request for floor of cabinet under kitchen sink to be replaced. 11. Mold/mildew will be removed from bathtub and tiles. 12. The closet door will be repaired.	8/27/09 8/27/09

alth Regulation Administration

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	[redacted]

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTH CARE RESOURCES	2908 RITTENHOUSE ST, NW WASHINGTON, DC 20015

4) ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 090	Continued From page 4 open them in both directions. Exterior: 13. The vent from the dryer leading to the exterior of the house contained an abundant accumulation of lint. This presented a potential fire hazard. The Qualified Mental Retardation Professional was present during the inspection and acknowledged the above-mentioned observations.	I 090	13. The vent will be cleaned and check after each wash.	
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Observation and interview revealed that the GHMRP failed to ensure that caustic agents were not stored in locked cabinets. The finding includes: Observation on June 26, 2009, starting at 10:39 a.m., revealed that powdered dishwasher detergent was being stored in a unlocked cabinet underneath the sink in the bathroom located on the second floor . The Qualified Mental Retardation Professional was present during the inspection and acknowledged the above-mentioned observation.	I 095	- The Lead Counselor will ensure all cleaning supplies are stored in a locked closet.	827/09

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	[redacted]

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EALTH CARE RESOURCES	2006 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 136	Continued From page 5	I 136		
I 136	3505.6 FIRE SAFETY Each GHMRP shall maintain records of each simulated fire drill. This Statute is not met as evidenced by: Based on record review and interview, the facility failed to implement a system to identify problems encountered with evacuation drills, for all four residents that reside in the facility. (Residents #1 - #4) The findings include: Review of the fire drill documents on June 24, 2009, at approximately 10:10 a.m., revealed the following concerns regarding the facility's system for evaluating the effectiveness of its fire drills: 1. System checklist: The fire drill record failed to evidence that the fire system, i.e. alarm panel, bells, and magnetic doors were consistently checked during drills. 2. Staffing during the drills: Interview with the Qualified Mental Retardation Professional (QMRP) on June 25, 2009, at approximately 3:00 p.m., revealed that the staffing pattern for the facility was two staff for the four residents on the day and evening shifts and one staff to the four residents on the night shift. On two occasions, however, there was only one staff on duty during the evening drills. The QMRP acknowledged the lack of the required staff during those drills. [Note: The drill reports did not indicate any concerns or problems had occurred during those	I 136	1. The QMRP will revise the Fire drills form. 2. The QMRP will revised the Organizational chart to reflect changes.	8/27/09

ealth Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EALTH CARE RESOURCES	2006 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 136	Continued From page 6 two drills.] 3. Review of the drills: The drill report form used by the GHMRP failed to designate a place or line on which whomever reviewed the results of the drill were expected to mark with their signature and date. The QMRP acknowledged that the fire drill reports had not been reviewed.	I 136		
I 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff; and... This Statute is not met as evidenced by: Based on review of the organizational chart that was presented, the GHMRP failed to ensure the organizational chart showed the numbers of supportive and direct care staff. The findings include: 1. On June 26, 2009, at 10:35 a.m., the Qualified Mental Retardation Professional (QMRP) presented an organizational chart (not dated) that did not show the number of supportive and direct care staff employed by the GHMRP. 2. In addition, the chart indicated a position of house manager. Interviews on the first day of survey, however, had revealed that the facility no longer had a designated house manager. Instead, management had changed the role and responsibilities of the "lead counselor." The QMRP acknowledged that the chart had not been updated to reflect the change.	I 186	See above response	

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 187	Continued From page 7	I 187		
I 187	3506.5(d) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (d) The lines of authority. This Statute is not met as evidenced by: Based on review of the organizational chart that was presented, the GHMRP failed to ensure the organizational chart accurately depicted the lines of authority. The finding includes: On June 26, 2009, at 10:35 a.m., the Qualified Mental Retardation Professional (QMRP) presented an organizational chart (not dated) that did not reflect the current lines of authority. For example, the chart did not reflect the position of QMRP as being between the operations manager and the house manager (now "lead counselor").	I 187	See above response	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter,	I 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	[redacted]

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2006 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 8 provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform their required duties. The findings include: Interview with the QMRP and review of the GHMRP's personnel files on June 25, 2009 at approximately 10:30 a.m., revealed the GHMRP failed to provide evidence that current health certificates were on file for the following: 1. one direct support staff (S#1), 2. the QMRP; and, 3. the residents' primary care physician. The QMRP was made aware of the finding and acknowledged the lack of required health documents.	I 206	The Human Resources Department will ensure training document is current and in each staff person file per regulation.	8/27/09
I 223	3510.4 STAFF TRAINING Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies. This Statute is not met as evidenced by: Based on interview and review of staff training records, the GHMRP failed to make available for review agendas for all staff in-service training. The findings include: On June 24, 2009, beginning at 10:25 a.m., review of the staff in-service training records revealed that on May 28, 2009, training had been	I 223		

ATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0951	A. BUILDING _____ B. WING _____	06/26/2009

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 223	Continued From page 9 provided on the following: 1. sexuality, 2. adaptive equipment, and 3. behavior management. There were no agendas, however, that described what topics/information had been covered during said training. When asked later that morning, the Qualified Mental Retardation Professional stated that there was no additional information available for review.	I 223	The QMRP will ensure all training provided will have agendas attached and training materials.	8/27/09
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review and interview, the QHMRP failed to have evidence of current certification to implement emergency measures for all of the residents in the facility. The findings include: 1. Review of personnel records on June 25, 2009 at approximately 11:00 a.m., revealed no documented evidence of current CPR/(Heimlich Maneuver) certifications for 5 of 5 staff members the house manager and 2 Licensed Practical Nurses.	I 227	The Human Resources Department will ensure training document is current and in each staff personnel file per regulation.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	[illegible]

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2606 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 227	Continued From page 10 2. Review of personnel records on June 25, 2009 at approximately 11:00 a.m., revealed no documented evidence of current First Aid certifications for 5 of 5 staff members and the house manager.	I 227		
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents' records were kept current, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. On June 24, 2009, at approximately 8:15 a.m., interview with Resident #1 revealed that she had been admitted to the GHMRP in May 2008. On June 26, 2009, at approximately 9:30 a.m., the Qualified Mental Retardation Professional (QMRP) also stated that Resident #1 had been admitted sometime on or around May 6, 2008. During the previous two days of survey, however, review of her Health Passport (HP, not dated), nursing records, Individual Support Plan (dated June 11, 2008) and other habilitation and medical records revealed that they failed to reflect a date of admission. The earliest nursing progress note in her record was dated August 1, 2008, in which the LPN wrote: "<resident's name> was a new individual met today, alert in no acute distress... No medical information received at this time. Still waiting for case manager to bring medical history..." The earliest Nurse Monthly Note was for the month of August 2008. The QMRP	I 291	1. The QMRP will ensure a admission form is in each individual record with all contact information.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0001	A. BUILDING _____ B. WING _____	[redacted]

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2006 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 291	Continued From page 11 agreed to seek nursing notes from the period May - July 2008 or other documentation to determine the resident's actual date of admission. No additional information was presented, however, before the survey ended later that day. 2. On June 24, 2009, at approximately 10:00 a.m., interview with the QMRP revealed that Resident #1's aunt was her designated surrogate health care decision maker. Review of Resident #1's Health Passport (not dated) and other habilitation and medical records, however, failed to show a phone number listed for the aunt. When the QMRP was asked for the aunt's phone number and address on June 25, 2009, at approximately 2:45 p.m., she replied that they should be listed on the Health Passport (HP). The QMRP then looked at Resident #1's HP and acknowledged that it did not reflect a family member, next of kin or guardian/designated health care decision maker, as required by the GHMRP's policies. She then offered to call the Department of Disability Services service coordinator to obtain the phone number. 3. On June 24, 2009, interviews with the registered nurse and QMRP, followed by review of Resident #1's medical records revealed the current primary care physician's name and office address located in Maryland. Resident #1's Health Passport (not dated), however, reflected the name and contact information of a former doctor as being her primary care physician. Later that day, the QMRP confirmed that the resident's PCP had changed "some time ago" and that the Health Passport had not been updated, as required by the GHMRP's policies. 4. On June 24, 2009, beginning at 1:04 p.m., review of Resident #1's HP revealed that it had	I 291	2. The QMRP will ensure all family contact information is listed and updated on the Health Passport. 3. See above response to # 2 8/27/09	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0001	A. BUILDING _____ B. WING _____	[illegible]

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2908 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 291	Continued From page 12 not been updated to reflect the Megace appetite stimulant and birth control pill that were prescribed in April 2009. 5. Cross-refer to I474. On June 24, 2009, at approximately 5:13 p.m., the registered nurse discovered that even though the blister pack showed that Resident #2 had received Risperdal from June 1, 2009 through June 24, 2009, the medication nurse had not initialed the medication administration record to document the administrations, in accordance with standard nursing practices and facility policies.	I 291	4. The QMRP and RN will ensure all Health Pass port is updated to include medication changes. 5. The RN Supervisor will ensure a physical count of medication occurs each month and ensure LPN sign off on all medication given daily. The RN supervisor will report discrepancies to the PCP.	8/27/09
I 372	3519.3 EMERGENCIES Each GHMRP shall post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident ' s physician, and the agency ' s on-duty administrator. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to post by each telephone emergency numbers, which include at least fire and rescue squads, the local police department, each resident's physician, and the agency's on-duty administrator. The findings include: 1. On June 26, 2009, at 10:37 a.m., there was no list of emergency contact numbers posted near the telephone located in the living room. 2. A minute later, observations revealed that there was no list of emergency numbers posted near the telephone/fax machine located in the home office downstairs.	I 372	1. The QMRP will ensure all emergency contact number is posted by each phone in the facility and all staff receive training. 2. See response to #1 above	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	08/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 372	Continued From page 13 The Qualified Mental Retardation Professional acknowledged that there were no emergency numbers posted at that time. She stated that the lists had been removed "several months" earlier, when the facility was painted.	I 372		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for one of the four resident of the facility. (Resident #2) The findings include: 1. On June 24, 2009, at approximately 9:45 a.m., review of unusual incident reports (UIR) revealed that Resident #2 had been taken to the emergency room on May 12, 2009 due to feeling lightheaded. She was admitted with a diagnosis of high blood pressure. The resident was	I 379	1. The QMRP will ensure that all staff are trained or re-trained on incident Management and reporting incidents as required to the different agencies.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EALTH CARE RESOURCES	2006 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 14 released on May 13, 2009. Further review of the UIR failed to show evidence that the hospitalization had been reported to DOH. 2. Another UIR documented that on May 9, 2009, Resident #2 had been transported to the emergency room after results of blood tests drawn the previous day indicated a low serum potassium level. Further review of the UIR failed to show evidence that the incident had been reported to DOH. A pre-survey review of incident records maintained at the Health Regulation Administration failed to show evidence that any incidents, including emergency room visits, had been reported since the previous survey. This is a repeat deficiency. ********** Previously, the Licensure Report, dated April 15, 2008, included the following: Review of the Resident #1's medical records on 4/14/08 at approximately 10:20 AM revealed a nurse's note dated 8/13/07. According to the nurse's note, Resident #1 had a seizure and was transported to a hospital via ambulance. Interview with the Qualified Mental Retardation Professional (QMRP) on 4/15/08 at 2:27 PM revealed that she had forwarded the incident report to the main office for processing. The QMRP stated that the office should have forwarded the incident report to the Department of Health (DOH). There was no documented evidence that the DOH was notified of these aforementioned incident as required.	I 379	2. See response to #1 above	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0061	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 15	I 401		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to secure nutritional, ophthalmology, sexuality and/or psychiatric evaluations timely, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. The GHMRP failed to ensure nutritional evaluations when indicated, as evidenced by the following: On June 24, 2009, at 1:48 p.m., review of Resident #1's medical record revealed that on April 3, 2009, her primary care physician (PCP) prescribed Megace 10cc by mouth every morning, as an appetite stimulant. The resident's weight had been documented at 95 pounds on November 18, 2008 and remained low. The resident's Medication Administration Record (MAR) documented that she began receiving Megace on April 9, 2009. At 2:48 p.m., her Health Management Care Plan (HMCP), dated December 30, 2008 and March 30, 2009, indicated that she was "under ideal body weight ... maintain prescribed diet ... monthly weight ..." Further review of Resident #1's record revealed no evidence that she had been evaluated by a nutritionist. On June 25, 2008, beginning at	I 401	1. The QMRP and Service Coordinator will ensure a Nutritionist Assessment will be provided.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0061	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 16 approximately 12:51 p.m., telephone interview with Resident #1's Department of Disability Services (DDS) service coordinator revealed that the resident's nutritional status was not discussed at her recent (June 11, 2009) annual team meeting and she was previously unaware that the resident had recently started receiving an appetite stimulant. She confirmed that to date, Resident #1 had not received a nutritional evaluation. 2. The GHMRP failed to ensure ophthalmology evaluations when indicated, as evidenced by the following: On June 24, 2009, at approximately 1:10 p.m., review of Resident #1's Health Passport (not dated) revealed that she wore eye glasses. The resident had not been observed wearing eye glasses earlier that day in her home. Later, at approximately 2:50 p.m., review of her HMCP (dated December 30, 2008 and March 30, 2009) revealed that she should be evaluated by an ophthalmologist "annually and PRN." This was also recommended in her psychological evaluation dated April 17, 2008 and her Individual Support Plan, dated June 11, 2008, also indicated that she had eye glasses. There was no evidence, however, that she had received an ophthalmology evaluation either before, or after, her admission to the GHMRP in May 2008. On June 26, 2009, at approximately 10:26 a.m., interview with the QMRP revealed that she had not seen Resident #1 wear eye glasses since she was admitted to the facility more than one year earlier. The QMRP then indicated that the resident had a vision appointment scheduled for either July 8 or 9, 2009. It should be noted that on June 26, 2009, at 9:52	I 401	2. The QMRP and the LPN will schedule a Vision to clarify the need for eye glasses.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2006 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 17 a.m., review of the facility's policies and procedures revealed that residents' ophthalmology records were to be updated "annually in conjunction with the ISP." 3. The GHMRP failed to ensure sexuality assessments when indicated, as evidenced by the following: a. On June 24, 2009, at 1:17 p.m., a brief interview with the registered nurse (RN) revealed that Resident #1 had been admitted approximately one year earlier. The RN stated that the resident saw a boyfriend every other weekend outside of the home, was sexually active and took birth control pills. While the RN indicated that she had "counseled" the resident regarding sexuality issues, she was "not sure" whether the resident had received a sexuality assessment. Approximately six minutes later, however, the RN returned and informed the surveyor that she had just spoken with the QMRP and the QMRP had informed her that Resident #1 was not sexually active and that contact with the boyfriend was mostly via telephone. At approximately 1:35 p.m., review of Resident #1's June 9, 2009 Medical Evaluation (prepared by the primary care physician, PCP) revealed that the space designated for documenting her "Social and Sexual History" had been left blank. Subsequent review of the PCP's progress notes, however, revealed that on April 3, 2009, the PCP wrote: "Patient sexually active - needs to be on pregnancy prevention." The PCP wrote an order that day for OrthroTricycline LO, as a means of birth control. The resident began receiving the medication on April 9, 2009. Further review of the resident's record revealed an Annual Report of Acute/Chronic Health Concerns document,	I 401	3. The RN will ensure the individual's is given a sexuality Assessment.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 18 dated June 10, 2009, in which the RN wrote: "Sexual counseling will continue as individual is sexually active." The next day, on June 25, 2009, at approximately 2:25 p.m., review of Resident #1's behavior data revealed that on January 4, 2009, staff wrote: "<Resident #1's name> was caught again in <Resident #4's name> bed on January 3, 2009. Staff ask her <sic> remove her body. Individual responded." The QMRP was asked about the staff note. Initially, she stated that she was previously unaware that Resident #1 had been asleep in another individual's bed. Resident #1 had her own bedroom. The QMRP then speculated that Resident #1 may have fallen asleep while watching television in Resident #4's bedroom. Further review of Resident #1's behavior data revealed the following: - December 14, 2008: "Inappropriate touching client." - January 6, 2009: staff documented having found both Resident #1 and Resident #2 in bed with Resident #4. - January 7, 2009: "<Resident #1's name> rubs on <Resident #3's name> leg. <Resident #3's name> said stop. Staff told her that's unacceptable behavior, she apologized." Resident #1's record included an April 17, 2008 Psychological Evaluation that included the following: "... has a history of inappropriate touch. The behavior was speculated to have its origins in sexual abuse." The resident's Social Work Assessment, dated June 11, 2008 included the	I 401		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0001	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 19 following: "...boyfriend who gives her money. Reportedly, her boyfriend is forty years old." During a follow-up interview with the QMRP on June 26, 2009, at 9:14 a.m., the QMRP referred to the four residents as "consenting adults." She then acknowledged that Resident #1 had not received a sexuality assessment during the two Individual Support Plan cycles - June 2008 and June 2009 - since she was admitted to the facility in May 2008. It should be noted that on June 26, 2009, at 10:05 a.m., review of the facility's Human Sexuality Policy revealed the following: "During the ISP process, if indicated by the Social Worker/Case Manager, the sex educational needs of the individual are reviewed with the Interdisciplinary Team (IDT)... the IDT develops the educational plan... covers all aspects of sexual behavior... Any individual who is sexually active is assessed to determine his/her ability to maintain a healthy sexual lifestyle. Treatment and intervention are determined by the IDT..." There was no evidence, however, that the facility had implemented its policy. b. During the survey, from June 24 through June 26, 2009, the air conditioning unit at the group home was not operating. The QMRP made arrangements for the residents to stay in a hotel until it was repaired. While in the kitchen on June 24, 2009, at approximately 5:50 p.m., Resident #4 stated that she was going to room with Resident #1 at the hotel. In response, Resident #2 stated in a firm tone of voice "no, I'm staying in the room with <Resident #1's name>," with emphasis placed on the word "I." Review of Resident #1's record, revealed a	I 401	See above response to # 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0001	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 20 human sexuality assessment dated November 2, 2007. Further review of the assessment, however, revealed that under the category of "experience with homosexuality, heterosexuality and masturbation," a nurse had indicated "unknown." Follow-up interview with the QMRP on June 26, 2009, at approximately 11:25 a.m. revealed that she was not aware of any interest that Resident #2 might have in sexuality or relationships. The QMRP was then informed of the conversation that was observed on June 24, 2009. The QMRP acknowledged that a current human sexuality assessment should be conducted to explore any changes in the residents' knowledge, interests and training needs regarding sexuality. 4. The GHMRP failed to ensure psychiatric evaluations when indicated, as evidenced by the following: a. On June 25, 2009, at 1:37 p.m., interview with the QMRP revealed that although Resident #1 had been seen by a psychiatrist on March 4, 2009, and had begun receiving Depakote 250 mg for "mood stability," there was no psychiatric evaluation report available for review. She further acknowledged that there had been delays in obtaining a comprehensive psychiatric evaluation. b. During the medication observation on June 24, 2009, at approximately 5:10 p.m., Resident #2 received Seroquel 300 mg. Review of her physician's orders revealed that this medication was given for the target behaviors of physical aggression, verbal aggression, non-compliance, crying and making false allegations. Further review of the record failed to show evidence that the resident had received a psychiatric	I 401	4. The QMRP will contact the Psychiatrist and Primary Care Physician to ensure the individual receive a Psychiatric Assessment and the PCP confirms the diagnoses.	9/15/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 21 assessment prior to the administration of this medication. Interviews with the QMRP on June 25, 2009, verified that to date, she had not received a psychiatric evaluation.	I 401		
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide habilitation and training on the use of an electric toothbrush as recommended by the dentist, for one of the two residents in the sample. (Resident #1) The findings include: On June 24, 2009, at 3:30 p.m., review of Resident #1's dental records revealed that on November 13, 2008, her dentist had found moderate calculus, moderate plaque, moderate gingivitis, caries (a cavity) in tooth #16 and an impaction with tooth #17. The dentist recommended fillings, dental restoration and "better brushing supervision." The cavity in tooth #16 was filled on January 6, 2009, at which time the dentist again found gingivitis. New recommendations included using an electric toothbrush. On March 16, 2009, the dentist again found moderate calculus, moderate gingival inflammation and moderate periodontal disease. Resident #1 was interviewed in her home later	I 432	The QMRP will ensure an electric tooth brush is purchase and the individual is trained on how to use electric toothbrush.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 432	Continued From page 22 that afternoon, beginning at approximately 4:50 p.m. She stated that her dentist had recommended that she floss, and brush her teeth twice every day. She said staff supervised her while brushing. Further interview, however, revealed that she used a regular toothbrush. She stated that she did not recall anyone speaking with her regarding using an electric toothbrush and she did not own one. On June 25, 2009, at approximately 10:30 a.m., interview with the Registered Nurse (RN) revealed that she was previously unaware that a dentist had recommended an electric toothbrush. Review of Resident #1's Monthly Nurse Note for January 2009 (prepared by the LPN Coordinator and signed-off by the RN) did reflect the January 6, 2009 dental appointment. The note, however, mistakenly stated that "0 gum disease noted or reported. Routine dental checkup ..." The note also failed to reflect the recommended electric toothbrush. At 2:15 p.m., review of the January 2009 Qualified Mental Retardation Professional (QMRP) Monthly report, revealed no information regarding the resident's dental appointment or status. At approximately 2:43 p.m., interview with the QMRP revealed that she too was previously unaware that the dentist had recommended an electric toothbrush. She acknowledged that Resident #1 was without an electric toothbrush and, therefore, had not received any training on its proper use.	I 432	The QMRP and RN will review all medical consultation to ensure recommendation is followed	8/27/09
I 474	3522.5 MEDICATIONS Each GHMRP shall maintain an individual medication administration record for each resident. This Statute is not met as evidenced by:	I 474		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0001	A. BUILDING _____ B. WING _____	06/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 474	Continued From page 23 Based on observation, interview and record review, the GHMRP's nursing staff failed to ensure medication administration records (MAR) were reviewed and maintained, for one of the two residents in the sample. (Resident #2) The finding includes: On June 24, 2009, at approximately 5:13 p.m., the registered nurse (RN) prepared to give Resident #2 her medication. The RN compared each bubble package to the MAR prior to administering the medication. Resident #2 received Tegretol 400 mg and Topamax 150 mg which were administered by the RN. As the RN prepared to administer Risperdal, she reviewed the MAR and discovered that even though the blister pack showed that the medication had been administered, there were no nurses' initials in the boxes for June 1, 2009 through June 24, 2009. The RN called the regularly-scheduled medication nurse to ascertain the reason why she had not documented the administrations thus far in June. The medication nurse indicated that she had not initialed the MAR because the administration time had not been specified on the MAR. The RN acknowledged that residents' MARs had not been reviewed and maintained during the month of June.	I 474	The RN and the LPN will monitor the MAR weekly to ensure the nurse has Sign her initials.	8/27/09
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by:	I 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0061	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 24 1. Based on interview and record review, the GHMRP failed to ensure the right to be free of unecessary medications, for two of the two residents in the sample. (Residents #1 and #2) [Title 7, Chapter 13, § 7-1305.05(h), formerly § 6-1965(h)] The findings include: a. On June 24, 2009, at approximately 8:26 a.m., interview with the lead counselor revealed that Resident #1 had recently been prescribed psychotropic medications. This was confirmed later that morning, at approximately 10:00 a.m., through interview with the Qualified Mental Retardation Professional (QMRP). The QMRP stated that the resident had been to a psychiatrist in March 2009 and the psychiatrist had prescribed Depakote 250 mg. The QMRP also stated that the resident's aunt was her designated surrogate health care decision maker. 1) Resident #1's medical records were reviewed on June 24, 2009, beginning at 1:04 p.m. According to her medication administration record (MAR), she had been taking Depakote 250 mg every evening on March 5, 2009 for "mood disorder." According to her Individual Support Plan, dated June 11, 2008, the resident lacked the capacity to make informed decisions regarding medical treatment, therapies, habilitation, finances and life planning. Further review of her record, however, failed to show evidence that her aunt had been informed of the proposed medication, to include a discussion of potential benefits and risks associated with taking Depakote. Interview with the QMRP on June 25, 2009, at 2:37 p.m., confirmed that the aunt had not been informed of the medication. The aunt had not attended Resident #1's recent (June 11,	I 500	1. The QMRP will prepare written information on the risk and benefits of proposed treatments. The QMRP will get signed consents from family member. The QMRP obtain signed consents at least annually and more frequently if current treatment needs modification.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-8881	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	[redacted] NW WASHINGTON, DC [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 25 2009) annual team meeting. The QMRP reported having mailed guardianship-related documents to the aunt on May 28, 2009; however, there had been nothing returned to the facility. 2) There was no written consent for the medication in Resident #1's records, even though the facility's policies (reviewed on June 26, 2009, at 10:01 a.m.) included the following: "Ensure that no restrictive treatment or therapy is implemented without the written, informed consent of either the person served or his/her legal guardian or representative. Ensure the Human Rights Committee reviews the prescribed treatment and provides written approval as the least restrictive treatment possible for the person servd." 3) There was no evidence that the GHMRP implemented less-restrictive intervention strategies before the introduction of psychotropic medication, in accordance with facility policies. Resident #1's record did not include a behavior support plan (BSP). On June 25, 2009, at approximately 3:20 p.m., interview with the QMRP revealed that a psychologist recently had developed a formal, written BSP at the request of the Department of Disability Services (DDS) service coordinator. However, the QMRP acknowledged that the home was without a copy of the BSP. She also acknowledged that the GHMRP had not implemented less-restrictive intervention strategies before introducing drugs (i.e. Depakote). Telephone interview with the DDS service coordinator earlier that afternoon, at 12:51 p.m. revealed that a "behavioral diagnostic assessment" had been prepared before March 2009. She did not elaborate on what, if any, training/intervention strategies might have been recommended in the assessment. She further indicated that it would be updated to reflect the	I 500	2. See response to #1 above 3. The QMRP will contact the Psychologist to develop, a monitoring tool. and oversee all BSP to ensure all other measures were exhausted before restrictive controls were implemented.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0061	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2906 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 26 use of medication. When asked about a BSP, she directed the surveyor to look for a psychiatric evaluation. The QMRP, however, had already acknowledged that the resident had not yet received a comprehensive psychiatric evaluation. On June 26, 2009, at 10:01 a.m., review of the facility's policies and procedures revealed the following: "Restricted controls are permitted only... as a last resort, when active treatment strategies have been considered/attempted... when other less intrusive or restricted methods have been ineffective... The planned use of restricted controls shall be based on a comprehensive assessment of the individual's skills and abilities... Psychotropic medications shall not be the first treatment of choice for behavior problems..." 4) On June 25, 2009, at approximately 3:15 p.m., the facility's Human Rights Committee (HRC) minutes were reviewed with the QMRP. The resident's Depakote was first reflected in minutes that were dated May 28, 2009, almost 3 months after she began taking it. The QMRP acknowledged that the committee had not reviewed the proposed medication prior to initiation of the drug. 5) On June 26, 2009, at 10:01 a.m., review of the facility's policies revealed the following: "... Ensure the Human Rights Committee reviews the prescribed treatment and provides written approval as the least restrictive treatment possible for the person served." Review of the May 28, 2009 HRC minutes, however, failed to show evidence that the committee had sought to determine whether less-restrictive strategies had been ineffective before the introduction of Depakote.	I 500	5. The HRC will more fully develop and document the process by which restrictive measure are reviewed and approved. The process will include HRC review of written informed consent for restrictive measures.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 27 b. Review of Resident #2's medical record on June 26, 2009, at approximately 11:00 a.m., revealed the resident was prescribed Valium 5 mg on March 18, 2009 prior to a medical procedure. Her MAR documented that the medication was administered on March 19, 2009. Further review of the record failed to show evidence that informed consent had been obtained from her mother, who was her designated surrogate health care decision maker. Interview with the QMRP later that day, at approximately 11:15 a.m., confirmed that they had not obtained informed consent from the resident's mother. They had, however, taken it to the HRC. There was no evidence that the GHMRP implemented less-restrictive behavior intervention strategies before the introduction of psychotropic medication (sedative), in accordance with facility policies. 2. Based on interviews and record review, the GHMRP failed to implement policies to ensure that Resident #1 was granted the appropriate level of privacy for sexual expression and/or was protected from potential sexual exploitation. [Title 7, Chapter 13, § 7-1305.02), formerly § 6-1962] The findings include: Cross-refer to I401.3.a. On June 24, 2009, at 1:17 p.m., interview with the registered nurse (RN) revealed that Resident #1 saw a boyfriend every other weekend outside of the home, was sexually active and took birth control pills. Approximately six minutes later, however, the RN returned and informed the surveyor that she had just spoken with the QMRP and the QMRP had informed her that Resident #1 was not sexually	I 500	b. See response to #1 above 2. See response to 1401 # 3	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2006 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 28 active and that contact with the boyfriend was mostly via telephone. At 2:58 p.m., the RN also stated that "staff in the home say she is always supervised when she leaves the home." An April 3, 2009 primary care physician note indicated: "Patient sexually active - needs to be on pregnancy prevention." The resident began taking OrthroTricycline LO, as a means of birth control on April 9, 2009. Further review of the resident's record revealed an Annual Report of Acute/Chronic Health Concerns document, dated June 10, 2009, in which the RN wrote: "Sexual counseling will continue as individual is sexually active." Resident #1 was interviewed later that afternoon, beginning at 4:50 p.m. She stated that she could visit with her boyfriend whenever she wanted. The next day, on June 25, 2009, at approximately 2:25 p.m., review of Resident #1's behavior data revealed four documented incidents when she was either discovered in another resident's bed or was observed touching a peer "inappropriately." An April 17, 2008 Psychological Evaluation included the following: "... has a history of inappropriate touch. The behavior was speculated to have its origins in sexual abuse." Her Social Work Assessment, dated June 11, 2008, indicated she had a: "...boyfriend who gives her money. Reportedly, her boyfriend is forty years old." At approximately 3:15 p.m., the facility's HRC minutes were reviewed with the QMRP. a. There was no indication that Resident #1's rights and responsibilities regarding sexuality had been discussed by the HRC. The QMRP acknowledged that the committee had not addressed sexuality since Resident #1 was admitted to the facility in May 2008.	I 500	a. The QMRP will meet with the LPN weekly to discuss any changes in the individual's and report changes to the HRC for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0001	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2000 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 29 b. During a follow-up interview with the QMRP on June 26, 2009, at 9:14 a.m., the QMRP referred to the four residents as "consenting adults." She acknowledged that Resident #1 had not received a sexuality assessment since she came to the facility in May 2008. At 10:30 a.m., the QMRP stated that Resident #1 carried "condoms in her purse." c. On June 26, 2009, at 10:05 a.m., review of the facility's Human Sexuality Policy revealed the following: "During the ISP process, if indicated by the Social Worker/Case Manager, the sex educational needs of the individual are reviewed with the IDT... the IDT develops the educational plan... covers all aspects of sexual behavior... Any individual who is sexually active is assessed to determine his/her ability to maintain a healthy sexual lifestyle. Treatment and intervention are determined by the IDT..." There was no evidence, however, that the facility and/or her interdisciplinary team (IDT) had sought a comprehensive sexuality assessment to guide the team. d. According to Resident #1's ISP, dated June 11, 2008, she lacked the capacity to make informed decisions regarding medical treatment, therapies and life planning. Although the resident's aunt was the reported surrogate health care decision maker, there was no evidence that she had been informed of the prescribed use of birth control pills. e. There was no evidence that the IDT had established the following: 1) the substance and nature of sexuality counseling that would be appropriate to this	I 500	b. See response to 1401 # 3 c. See response to 1401 # 3 d. See response to 1500 # 1 e. See response to 1401 # 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-9661	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2008 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 30 individual; 2) how best to ensure the resident's health and safety, including prevention of sexual exploitation; and, 3) the appropriate level of supervision (and/or privacy) that Resident #1 and her boyfriend should be granted if sexual contact is deemed appropriate. 3. Based on interviews and record review, the GHMRP failed to develop a system to maintain current health insurance (federal entitlement: Medicaid) to ensure that there were no delays in the residents receiving medications, for one of the two residents in the sample. (Resident #2) [Title 7, Chapter 13, § 7-1305.14, formerly § 6-1974] The finding includes: On June 24, 2009, at approximately 9:45 a.m., review of incident reports revealed that on April 28, 2009, one of Resident #2's prescribed medications (K-dur, a potassium supplement) was not available for administration due to expired Medicaid benefits. Further review of the resident's MAR revealed that the medication was not available from April 23, 2009 through April 29, 2009. In addition, review of the incident reports revealed that on May 9, 2009, Resident #2 had been taken to an emergency room due to decreased potassium levels. Interview with the QMRP on June 26, 2009, at approximately 11:30 a.m., revealed that it was the responsibility of the Department of Disability Services service coordinator to handle the renewal of residents' medicaid benefits. The	I 500	2. See response to 1401 # 3 3. See response to 1401 # 3 The DDS Service Coordinator will provide the QMRP with a list of renewal dates for each individual's.	8/27/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD12-0051	A. BUILDING _____ B. WING _____	06/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE RESOURCES	2006 RITTENHOUSE ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 31 QMRP then acknowledged that there was no system in place to ensure that the Medicaid renewal process was carried out timely, and/or what actions the GH/MRP would take to ensure that residents did not lose access to needed health care, including prescribed medications.	I 500		